SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Monumental Life Insurance Company-

Product Name: 2009 Conditional Receipt	SERFF Tr Num: AEGF-126201575	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 42745
Sub-TOI: L08.000 Life - Other	Co Tr Num: A0910R	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Neil Tomas	Disposition Date: 06/24/2009
	Date Submitted: 06/23/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 06/11/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/24/2009	Explanation for Other Group Market Type:
	State Status Changed: 06/24/2009
Deemer Date:	Created By: Neil Tomas
Submitted By: Neil Tomas	Corresponding Filing Tracking Number: SERT-5PGGKK159/00

Filing Description:
Re: Monumental Life Insurance Company - NAIC #468–66281 - FEIN #52-0419790

Form - Description - Replaces Form - Approved
A0910R - Conditional Receipt - A0310R - 07/18/2003

To Whom It May Concern:

We respectfully request that the above captioned form be considered for approval. This is a new Conditional Receipt

SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

that will replace our previously approved Conditional Receipt form, A0310R. A0910R will be used with all applications for Life and Health Insurance marketed to individual policyholders by captive agents.

Previously approved applications to be used in conjunction with A0910R:

A08100 - Life & Health Application – Approved 07/15/2008
A08101 - Life & Health Application – Approved 07/15/2008
A08102 - Cancer Application – Approved 07/15/2008
A08103 - Accident Application – Approved 07/15/2008
A95110AR - Agreement/Authorization – Approved 02/23/1998

Your prompt attention to this filing will be greatly appreciated. Please feel free to contact me if you have any questions or comments.

Sincerely,

Neil Tomas
Compliance Analyst
Phone: 410-685-2900, ext. 2034
Fax: 410-576-4554
ntomas@monlife.com

Company and Contact

Filing Contact Information

Neil Tomas, Compliance Analyst	NTomas@monlife.com
2 E Chase Street	410-685-2900 [Phone] 2034 [Ext]
Baltimore, MD 21202	410-576-4554 [FAX]

Filing Company Information

Monumental Life Insurance Company-	CoCode: 66281	State of Domicile: Iowa
4333 Edgewood Rd NE	Group Code: 468	Company Type: Life & Health
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(410) 685-2900 ext. [Phone]	FEIN Number: 52-0419790	

Filing Fees

SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	20 x Amount of Applications = Total
	20 x 1 = 20
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monumental Life Insurance Company-	$20.00	06/23/2009	28759017

SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/24/2009	06/24/2009

SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/24/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Conditional Receipt		Yes

SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: A0910R

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A0910R	Application/ Enrollment Form	Conditional Receipt	Initial		50.800	A0910R.pdf

CONDITIONAL RECEIPT

MONUMENTAL LIFE INSURANCE COMPANY
Home Office: Cedar Rapids, Iowa
Administrative Office: 2 East Chase Street, Baltimore, MD 21202

IMPORTANT NOTICE TO PROPOSED INSURED AND OWNER

Please Read This Receipt Carefully. No insurance will become effective prior to delivery of the policy and/or rider applied for unless and until all the conditions of this receipt are met. No agent, producer and/or broker is authorized to alter or waive any conditions of this receipt. Under no circumstances can a claim be made both under this receipt and under the policy and/or rider applied for should the policy and/or rider applied for be issued.

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY AND/OR RIDER:

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be as stated in applications required by the Company; and
2. On the Effective Date indicated below, an amount equal to the initial premium indicated by the mode of payment selected on the application must be submitted; the amount must be annual, semi-annual, quarterly or monthly; and
3. Any check or money order given in payment must be honored when first presented; and
4. All medical examinations, tests, x-rays and electrocardiograms initially required by the Company's written rules with regard to age and amount requested must be completed within sixty (60) days from the date of this receipt; and
5. On the Effective Date indicated below, any person proposed for coverage must be a risk acceptable for insurance exactly as applied for on a premium basis according to the Company's underwriting rules and standards.

EFFECTIVE DATE

If all the conditions above are met, insurance in the amount set forth below or the amount applied for, whichever is lower, subject to all the terms and conditions of the policy and/or rider applied for and as if the policy and/or rider applied for had been issued and delivered, will become effective on the LATER of: a) the date of the application or, b) the date of completion of all underwriting requirements stated in (4) above.

MAXIMUM AMOUNT

The liability of the Company prior to delivery of the policy and/or rider and under the receipt and application for insurance and/or accidental death benefits will not exceed one hundred and fifty thousand dollars ($150,000.00).

LIABILITY NOT ASSUMED

Each person proposed for insurance must meet the qualifications set forth in this receipt individually. If the Company determines, after completion of all underwriting requirements stated in (4) above, that any person proposed for coverage is not at least a standard risk according to the Company's underwriting rules and standards for the plan and amount of insurance applied for in the application or if any person proposed for coverage dies before completion of all the underwriting requirements stated in (4) above, then the Company assumes NO liability under the receipt and application for insurance with respect to that person.

RETURN OF MONEY

If any of the above stated conditions are not met, the liability of the Company shall be limited to the return of the amount remitted with this receipt. All returns shall be made without interest to or for the benefit of the owner. Any delay in returning the amount paid shall not be construed as approval of the application.

AGREEMENT

I understand and agree that: (1) any coverage provided under this receipt will be void if the application or this receipt contains any material misrepresentation or if the Proposed Insured dies by suicide; (2) any coverage of insurance available under this receipt will not begin unless all the CONDITIONS listed above are first met exactly; and (3) any coverage which takes effect through this receipt will terminate on the **EARLIEST** of the following: a) sixty (60) days after the date of this receipt; b) the date the policy and/or rider is delivered to the owner; c) the Effective Date of the policy and/or rider; d) the date the entire amount remitted with this receipt is returned; or e) the date the Company determines that the person proposed for coverage is not entitled to insurance as a standard risk on the plan and amount of insurance applied for under the Company's underwriting rules and standards.

If, after termination of coverage under this receipt pursuant to section (e) above, the Company is willing to issue a policy and/or rider on terms other than those applied for (rated policy and/or rider), no such rated policy and/or rider shall become effective until during the lifetime of the person proposed for insurance, the policy and/or rider is delivered to the Owner, the first full monthly premium on the rated policy and/or rider is delivered to the agent, and an acknowledgement referring to the rated policy and/or rider is signed by the Owner, and then only if there has been no change in the health of the person proposed for insurance since the date of this receipt. The decision to issue a rated policy and/or rider shall not create any liability on the part of the Company on a conditional receipt basis for any reason.

_____	_____	_____
Signature of Proposed Insured	Date of this Receipt	Signature of Owner if Other than Proposed Insured

Payment of $_____ has been received toward the premium for insurance with Monumental Life Insurance Company in the application having the same name and date of this receipt. I know of no reason why any person to be covered may not be eligible for insurance. I accurately represented the terms and conditions of this receipt to the Proposed Insured(s) and Owner(s).

_____

Signature of Agent

SERFF Tracking Number:	*AEGF-126201575*	*State:*	*Arkansas*
Filing Company:	*Monumental Life Insurance Company-*	*State Tracking Number:*	*42745*
Company Tracking Number:	*A0910R*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2009 Conditional Receipt*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Attached are the previously approved applications to be used in conjuction with the Conditional Receipt filed for approval. Please see the Filing Desciption for further details.

Attachments:

A08100.pdf
A08101.pdf
A08102.pdf
A08103.pdf
A95110AR.pdf

CERTIFICATION

THIS IS TO CERTIFY, that the forms listed below achieved the following Flesch Reading Ease Scores and are in compliance with the requirements of Arkansas Insurance Code ACA 23-80-206.

Form	Flesch Score
A0910R	50.8

MONUMENTAL LIFE INSURANCE COMPANY

Date: 06/23/2009

By: _____
Gerardo Puig
Assistant Vice President &
Assistant General Counsel

CRTARR.DOC

ISSUE DATE: APPLICATION FOR LIFE/HEALTH INSURANCE POLICY NO.

MONUMENTAL LIFE INSURANCE COMPANY

[HOME OFFICE: CEDAR RAPIDS, IA]

[ADMINISTRATIVE OFFICE: 2 E. CHASE ST. / BALTIMORE, MARYLAND 21202]

PART 1

1. Name of Proposed Insured:_____ 2. Phone No.:_____

3. Address: _____

4. Social Security No.:_____5. Birth Date:_____ Age:____

6. Sex:_____ 7. Birth Place:_____8. Height:_____ Weight:_____

9. Employer:_____ Phone No.:_____
   Employer Address:_____
   Industry: _____
   Occupation:_____

10. Plan of Insurance:_____ 11. Amount of Insurance:_____

12. Supplemental Riders and/or Benefits Requested:_____

13. Premiums Payable:_____ Payment Mode:_____

14. Full Names of All others Proposed for Coverage:

Name	Birth Place	Birth Date	Age	Sex	Height	Weight	Pending & Present Insurance	Relationship

15. Additional Insured:_____
   Employer:_____ Phone No.:_____
   Employer Address:_____
   Industry:_____
   Occupation:_____

16. Payor (if other than insured):
   Name:_____ Phone No.:_____
   Address:_____

17. Primary Beneficiaries:

Name	Relationship	Address	SSN	%

18. Contingent Beneficiaries (automatically becomes beneficiary upon death of the Primary):

Name	Relationship	Address	SSN	%

19. Owner(s):
Name:_____ Relationship:_____
Soc Sec No/Tax ID:_____ Phone No:_____
Address:_____

Name:_____ Relationship:_____
Soc Sec No/Tax ID:_____ Phone No:_____
Address:_____

20. Contingent owner (automatically becomes owner upon death of the Primary):
Name:_____ Relationship:_____
Soc Sec No/Tax ID:_____ Phone No:_____
Address:_____

21. Does proposed insured now have life or health insurance with this or any other company?
Life: YES [ ] NO [ ] Not Asked [ ] Health: Yes [ ] No [ ] Not Asked [ ]
If yes, give details:

Company	Policy Number	Life/Health	Year Issued	Amount	Accidental Death?	Waiver?	Pending?

22. Are all owners citizens of the United States?
If no, provide details at the end of Part 1 Yes [ ] No [ ] Not Asked [ ]

23. Are all proposed insureds citizens of the United States?
If no, provide details at the end of Part 1 Yes [ ] No [ ] Not Asked [ ]

EXPLAIN ALL YES RESPONSES AT THE END OF PART 1

24. Has any proposed insured in the past 2 years traveled or resided, or does any proposed insured intend to travel or reside, outside of the continental United States for more than 3 consecutive weeks? Yes [ ] No [ ] Not Asked [ ]

25. Provide all proposed insureds Drivers License Number(s):
Name:_____License number:_____State:_____
Name:_____License number:_____State:_____
Name:_____License number:_____State:_____

26. Within the past 5 years, has any proposed insured had his/her driver’s license suspended or revoked, had two or more moving violations or accidents or been convicted of, pled guilty or no contest to, driving under the influence of alcohol or drugs?
Yes [ ] No [ ] Not Asked [ ]

27. Within the past 3 years has any proposed insured participated in or within the next 12 months does any proposed insured intend to participate in flying as a pilot, racing a motor vehicle, underwater diving or any other similar sport, activity or avocation?
Yes [ ] No[ ] Not Asked [ ]

28. Is any proposed insured currently on probation, parole, or awaiting trial for an illegal activity or within the past 10 years, has a proposed insured been convicted of a felony? Within the past 5 years, has any proposed insured been convicted of a misdemeanor?
Yes [ ] No [ ] Not Asked [ ]

29. Will any existing life (including paid-up additions), health or annuity contracts be lapsed, surrendered, or borrowed against, reissued or converted (in order to reduce amount, premium, or period of coverage including surrender options) if the proposed policy is issued? Yes [ ] No [ ] Not Asked [ ]

30. Has any person to be covered applied for life or accident & health insurance without receiving the amount and plan applied for at the standard premium?
Yes [ ] No [ ] Not Asked [ ]

31. Special Request:

Details of YES answers (Identify question number, indicate applicable items).

PART 2 - Life/Health

1. Is any proposed insured currently hospitalized, residing in a nursing home, long term care facility, convalescent home, receiving hospice, home healthcare or waiting for an organ transplant (except corneal)? Yes [ ] No [ ] Not Asked [ ]

2. Has any proposed insured been diagnosed with, been treated for, or advised to receive treatment for Alzheimer's disease or dementia? Yes [ ] No [ ] Not Asked [ ]

3. Has any proposed insured been medically diagnosed, been treated for Acquired Immune Deficiency Syndrome (AIDS), any disease or disorder of the immune system or tested positive for antibodies to the AIDS (HIV Virus)? Yes [ ] No [ ] Not Asked [ ]

4. a. Name(s) of primary health care provider: _____
Phone No: _____
Address: _____

b. Date(s) last consulted: _____

Yes answers explained in detail at the end of part 2 questions

5. Is any proposed insured taking any medication or been prescribed a medication that has not been filled? Yes [ ] No [ ] Not Asked [ ]

6. Within the past 12 months, has any proposed insured used a tobacco or nicotine product? Yes [ ] No [ ] Not Asked [ ]

7. Within the past 12 months, has any proposed insured lost 25 or more pounds? Yes [ ] No [ ] Not Asked [ ]

8. Within the past 7 years, has any proposed insured been told that he/she has been diagnosed or treated by a licensed health care provider or taken medication for:

a. Allergies, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, pneumonia, shortness of breath, sinusitis, sleep apnea, tuberculosis (TB) or other disease or disorder of the lung or respiratory system? Yes [ ] No [ ] Not Asked [ ]

b. Anemia, aneurysm, blood clot, phlebitis, coronary artery disease (CAD), chest pain, angina, cholesterol, congestive heart failure, edema, heart attack, heart murmur, high blood pressure, irregular heartbeat, palpitations, stroke, transient ischemic attack (TIA) or any other disease or disorder of the heart, circulatory system, or arteries? Yes [ ] No [ ] Not Asked [ ]

c. Cirrhosis, crohn's, ulcerative colitis, diverticulitis, fatty liver, gastritis, gastroesophageal reflux, hepatitis, hernia, pancreatitis, stomach bypass, stomach banding, stomach stapling, ulcer or other disease or disorder of the stomach, liver, colon, rectum, intestines? Yes [ ] No [ ] Not Asked [ ]

d. Attention deficit disorder (ADD/ADHD), anxiety, autism,depression, dizziness, vertigo, down's syndrome, fainting, schizophrenia, seizures, epilepsy, convulsions, or other disease or disorder of the brain or nervous system, or mental or nervous disorder, or consulted a psychiatrist or psychologist? Yes [ ] No [ ] Not Asked [ ]

e. Amputation, arthritis, rheumatoid arthritis, osteoarthritis, cerebral palsy, concussion, fibromyalgia, fracture, herniated disc, multiple sclerosis, osteoporosis, paralysis, Parkinson's, or other disease or disorder of the muscles, bones, joints, or connective tissue? Yes [ ] No [ ] Not Asked [ ]

f. Dialysis, infection, kidney stones, menstrual irregularity, nephritis, or other disease or disorder of the kidney, bladder, prostate, breast, or reproductive organs, urine abnormality or sexually transmitted disease? Yes [ ] No [ ] Not Asked [ ]

g. Diabetes or other disease or disorder of the thyroid, pituitary, adrenal glands? Yes [ ] No [ ] Not Asked [ ]

h. Cancer, cysts, growths, Hodgkin's, leukemia, lupus, lymphoma, melanoma, polyps, tumors or other disease or disorder of the skin or malignant disorders? Yes [ ] No [ ] Not Asked [ ]

9. Within the past 10 years, has any proposed insured received advice or sought advice or counseling by a licensed health care provider for the use of drugs or alcohol or has any proposed insured used amphetamines, barbiturates, cocaine, heroin, opium, LSD, PCP, hallucinogens, marijuana, narcotics or any other controlled substance except that taken in doses as prescribed by a physician? Yes [ ] No [ ] Not Asked [ ]

10. Within the past 5 years, has any proposed insured consulted, been treated or examined by a licensed health care provider for reasons not stated in the application? Yes [ ] No [ ] Not Asked [ ]

(Ask only if Premium Waiver or Multiple Coverage is applied for)

11. Within the past 7 years, has any proposed insured ever requested or received a benefit, discharge or rejection, payment or pension because of a disability, impaired condition, injury, or sickness? Yes [ ] No [ ] Not Asked [ ]

12. Within the past 12 months, excluding pregnancy, has any proposed insured had an illness or condition that prevented them from working at their job for more than 5 consecutive business days? Yes [ ] No [ ] Not Asked [ ]

(Ask only if combined amount applied for is $100,000 or greater and adult base or rider is less than age 60.)

13. Family History:
Father:
Age if living:
Age at death:
Cause:

Mother:
Age if living:
Age at death:
Cause:

Had a brother, or sister who was diagnosed and/or died from cancer, diabetes, stroke, heart or kidney disease or suicide? Yes [ ] No [ ] Not Asked [ ]

(Ask only if a proposed insured is less than 1 year old)

14. Birth weight: _____

Details of YES answers (Identify question number, indicate applicable items).

PART 2 - CANCER

1. Does any proposed insured now have health insurance with this or any other company? Yes [ ] No [ ] Not Asked [ ]
If yes, give details:

Company	Policy Number	Year Issued	Amount	Accidental Death?	Waiver?	Pending?

2. Is any person proposed for coverage also covered by:
a. Medicaid? Yes [ ] No [ ] Not Asked [ ]
b. Medicare? Yes [ ] No [ ] Not Asked [ ]
(If yes to Medicare, I received the "Important Notice to Persons on Medicare Form.")
Yes [ ] No [ ] Not Asked [ ]

3. a. Name(s) of primary health care provider: _____Phone No:_____
Address:_____

b. Date(s) last consulted: _____
Reason(s) for consultation:_____
(if more than one, enter in "Details". For additional insureds primary health care provider information enter in "Details").

4. Within the past 10 years, has any proposed insured been medically diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), any disease or disorder of the immune system, or tested positive for antibodies to the AIDS (HIV) virus? Yes [ ] No[ ] Not Asked [ ]

5. Within the past 10 years, has any proposed insured been diagnosed as having, been treated for, or had any indications of:

a. Any benign or malignant tumor, polyp, cyst, growth, tissue enlargement or lesion? Yes [ ] No [ ] Not Asked [ ]
b. Cancer, leukemia, Hodgkin's disease or any cancerous or pre-cancerous disorder of the skin or blood? Yes [ ] No [ ] Not Asked [ ]
c. Fibrocystic breast disease, ovarian cyst, or an abnormal PAP smear that was not subsequently followed by a normal PAP smear? Yes [ ] No [ ] Not Asked [ ]

6. Within the past 12 months, has any proposed insured had treatment for, any indications of, been advised of, or seen a physician for:

a. Any sores that have not healed? Yes [ ] No [ ] Not Asked [ ]
b. Any changes in the size, shape, or appearance of a wart, mole or birthmark? Yes [ ] No [ ] Not Asked [ ]
c. Any unexplained weight loss? Yes [ ] No [ ] Not Asked [ ]
d. Any abnormal PAP smear that was not subsequently followed by a normal PAP smear, mammogram, X-ray, Prostate Specific Antigen (PSA), CAT scan, or MRI? Yes [ ] No [ ] Not Asked [ ]
e. Crohn's disease, regional enteritis, ileitis, or ulcerative colitis? Yes [ ] No [ ] Not Asked [ ]
f. Unexplained weakness, fatigue, anemia, diarrhea, enlargement of a lymph node, lump or growth? Yes [ ] No [ ] Not Asked [ ]
g. Any abnormal or excessive bleeding, gastric ulcer, Barrett's Esophagus, or chronic hepatitis? Yes [ ] No [ ] Not Asked [ ]
h. Any persistent hoarseness, cough, blood in urine or stool, breast lump or discharge? Yes [ ] No [ ] Not Asked [ ]
i. Any recommended test or treatment not yet completed? Yes [ ] No [ ] Not Asked [ ]

Details of “YES” answers. (IDENTIFY QUESTION NUMBER, INDICATE APPLICABLE ITEMS: Include diagnoses, dates, duration and name and address of all attending physicians and medical facilities. INDICATE TO WHICH APPLICANT EACH EXPLANATION PERTAINS.)

PART 2 - ACCIDENT

1. Does any proposed insured now have accident insurance with this or any other company? YES [ ] NO [ ] Not Asked [ ]
   If yes, give details:

Company	Policy Number	Year Issued	Amount	Accidental Death?	Waiver?	Pending?

2. Within the past 7 years, has any proposed insured been told that he/she has been diagnosed or treated by a licensed health care provider or taken medication for:

   a. Diabetes or other disease or disorder of the thyroid, pituitary, adrenal glands? Yes [ ] No [ ] Not Asked [ ]

   b. Anemia, aneurysm, blood clot, phlebitis, coronary artery disease (CAD), chest pain, angina, cholesterol, congestive heart failure, edema, heart attack, heart murmur, high blood pressure, irregular heartbeat, palpitations, stroke, transient ischemic attack (TIA) or any other disease or disorder of the heart, circulatory system, or arteries? Yes [ ] No [ ] Not Asked [ ]

   c. Attention deficit disorder (ADD/ADHD), anxiety, autism, depression, dizziness, vertigo, down's syndrome, fainting, schizophrenia, seizures, epilepsy, convulsions, or other disease or disorder of the brain or nervous system, or mental or nervous disorder or consulted a psychiatrist or psychologist? Yes [ ] No [ ] Not Asked [ ]

   d. Amputation, arthritis, rheumatoid arthritis, osteoarthritis, cerebral palsy, concussion, fibromyalgia, fracture, herniated disc, multiple sclerosis, osteoporosis, paralysis, Parkinson's, or other disease or disorder of the muscles, bones, joints, or connective tissue? Yes [ ] No [ ] Not Asked [ ]

3. Within the past 10 years, has any proposed insured received advice or sought advice or counseling by a licensed health care provider for the use of drugs or alcohol or has any proposed insured used amphetamines, barbiturates, cocaine, heroin, opium, LSD, PCP, hallucinogens, marijuana, narcotics or any other controlled substance except that taken in doses as prescribed by a physician? Yes [ ] No [ ] Not Asked [ ]

Details of "YES" answers. (IDENTIFY QUESTION NUMBER, INDICATE APPLICABLE ITEMS: Include diagnoses, dates, duration and name and address of all attending physicians and medical facilities. INDICATE TO WHICH APPLICANT EACH EXPLANATION PERTAINS.)

MONUMENTAL LIFE INSURANCE COMPANY
HOME OFFICE: BALTIMORE, MD 21202

PART 3 - AGREEMENT/AUTHORIZATION

Application Lock-In Number: _____

AGREEMENT

I have reviewed all of the questions shown on the computer screen. I have also reviewed all of the answers and statements given in response to these questions. They are the answers and statements I provided, and they are true and complete to the best of my knowledge and belief. I understand that these answers and statements, once locked into the computer, cannot be changed. Any subsequent changes to this Application must be made on separate forms supplied by Monumental and signed by me. The answers and statements have been locked in with an assigned Application Lock-In Number. I understand that this Lock-In Number is unique. I have confirmed that the Application Lock-In Number shown at the top of this Agreement is the same as shown on the computer screen.

I understand that the Application consists of this Agreement together with all lock-in questions, answers and statements. Unless stated in this Application, no information given about any proposed insured will be considered to have been given to Monumental. I also understand that Monumental will rely upon the Application in the issuance of any policy. The Application will be attached to and made a part of that policy.

No agent has the authority to: (a) waive a complete answer to any question; or (b) change or waive any of the terms of an application receipt, or policy; or (c) waive any other rights or requirements of the Company.

If the first full premium due is paid when the Application is signed, the terms and limitations of the Conditional Receipt will apply. If insurance has not become effective under the terms of the Conditional Receipt, Monumental will not have any liability until: (a) the policy is delivered to and accepted by the owner; and (b) the first full premium is paid while all proposed insureds are living; and (c) at the time of payment and delivery, the health and insurability of all proposed insureds remains as stated in the Application.

I have received the M.I.B. Disclosure Notification and the Notice to Persons Applying for Insurance. I have paid $_____ and hold a Receipt, corresponding with this Application, for that amount.

INSURANCE FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The owner certifies, under penalty of perjury, that the owner's Social Security or Tax ID. number is correct and the owner is not subject to back-up withholding.

Signed at _____ _____
City State Proposed Insured

Date _____ _____
Spouse/Additional Insured

_____
Applicant/Owner
(if other than proposed insured)

APPROVED
FEB 23 1998
INSURANCE COMMISSIONER
STATE OF ARKANSAS

To the best of your knowledge and belief, does this application involve the replacement of any existing insurance or annuities? YES [ ] NO [ ]

Witnessed by _____ _____
Writing Agent District/Agency/Account

Form A95110AR

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance, or reinsuring company, the Medical Information Bureau Inc., Consumer Reporting Agency, or employer, having information as to diagnosis, treatment, and/or prognosis with respect to any physical or mental condition of any proposed insured, and any other non-medical information of any proposed insured, to give to the Monumental Life Insurance Company, or its legal representative or reinsurers, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Monumental Life Insurance Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by the Monumental Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request a copy of this Authorization. This Authorization will be valid for twenty-six months from the date shown below. A photocopy or facsimile of this Authorization will be as valid as the original.

_____
Date

_____
Proposed Insured
(if proposed insured is a minor, Signature of Parent, Guardian, or Person liable for child's support)

_____
Spouse/Additional Insured

_____
Names of Minor Children